Malpractice Payment Report Form for Insurance Companies

Reporting of judgments and settlements in accordance with § 27-26-5, Code of Alabama 1975

* indicates a required field

Full name of policy holder: *_____

Full name of physician: *_____

Address of physician involved in action:

Street address: *_____

Additional address:_____

City: * _____**State:** *_____ **Zip code:** *_____

Name of claimant: * _____

Summary of allegations: *

Case concluded by: *

☐ Judgment FOR physician

☐ Judgment AGAINST physician

☐ Settlement in OR out of court

Date and amount of: *

☐ Judgment

Amount:_____ Date: _____

OR

☐ Settlement

Amount:_____ Date: _____

Insured's contribution: * _____

 # - Do not include the cost of defense in this amount and if the "insured" is other than an individual physician, please indicate the amount charged against the physician on whom this report is submitted

Provide the company name (or entity), name of individual, address, phone number and email address for the individual submitting the report.

Company (or entity): *_____

Individual submitting form: *_____

Street address: *_____

Additional address: _____

City: *_____ State: *_____ Zip code: *_____

Telephone number: *_____

Your email address: *_____

Confirm your email address: *_____

Please email completed form to bmadderra@albme.org